

AMENDED IN ASSEMBLY APRIL 21, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

**ASSEMBLY BILL**

**No. 175**

**Introduced by Assembly Member Cohn**

January 23, 2003

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An act to *add Section 511.3 to the Business and Professions Code, to amend Section 1375.7 of the Health and Safety Code, to add Section 10178.4 to the Insurance Code, and to add Section 4610 to the Labor Code, relating to health care service plans.*

LEGISLATIVE COUNSEL'S DIGEST

AB 175, as amended, Cohn. ~~Health care service plans: provider contracts.~~

Existing law, the Knox-Keene Health Care Service Plan Act of 1975, provides for the licensure and regulation of health care service plans by the Department of Managed Health Care. Under existing law, a violation of the act's provisions is a crime. ~~The act prohibits certain terms in a contract between a plan and a health care provider that are designated the Health Care Providers' Bill of Rights.~~ Existing law also provides for the regulation of insurers by the Department of Insurance.

Existing law imposes certain requirements on payors, including health care service plans, specialized health care service plans, disability or liability insurers, workers' compensation insurers, employers, or any other 3rd party that is responsible to pay for health care services provided to beneficiaries by health care providers, and a failure to comply with the requirements renders the payor liable to pay the nonpreferred rate.

~~This bill would add a provision to the Health Care Providers' Bill of Rights that prohibits a contract term requiring a provider to furnish services to a person who is not enrolled directly with the plan if other specified contracts apply require a reduced rate by a health care provider to a payor that is based on the provider's participation in a network or panel to be governed by the underlying contract between the provider and the contracting agent.~~

Because the bill would add a requirement to the ~~act~~ provisions governing a health care service plan, a violation of which is a crime, it would impose a state-mandated local program.

The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

*The people of the State of California do enact as follows:*

- 1 SECTION 1. *Section 511.3 is added to the Business and*
- 2 *Professions Code, to read:*
- 3 511.3. (a) *In order to prevent the improper use of a health*
- 4 *provider's contract when being sold, leased, or transferred, every*
- 5 *arrangement that results in a payor paying a health care provider*
- 6 *a reduced rate from billed charges for health care services based*
- 7 *on the health care provider's participation in a network or panel*
- 8 *shall be governed by the underlying contract between the health*
- 9 *care provider and the contracting agent, regardless of the terms of*
- 10 *the contract between the contracting agent and the payor.*
- 11 (b) *For purposes of this section, the following terms shall have*
- 12 *the following meanings:*
- 13 (1) *"Contracting agent" has the meaning set forth in*
- 14 *paragraph (2) of subdivision (d) of Section 511.1.*
- 15 (2) *"Payor" has the meaning set forth in paragraph (3) of*
- 16 *subdivision (d) of Section 511.1.*
- 17 SEC. 2. *Section 1375.7 of the Health and Safety Code is*
- 18 *amended to read:*



1 1375.7. (a) This section shall be known and may be cited as  
2 the Health Care Providers' Bill of Rights.

3 (b) No contract issued, amended, or renewed on or after  
4 January 1, 2003, between a plan and a health care provider for the  
5 provision of health care services to a plan enrollee or subscriber  
6 shall contain any of the following terms:

7 (1) (A) Authority for the plan to change a material term of the  
8 contract, unless the change has first been negotiated and agreed to  
9 by the provider and the plan or the change is necessary to comply  
10 with state or federal law or regulations or any accreditation  
11 requirements of a private sector accreditation organization. If a  
12 change is made by amending a manual, policy, or procedure  
13 document referenced in the contract, the plan shall provide 45  
14 business days' notice to the provider, and the provider has the right  
15 to negotiate and agree to the change. If the plan and the provider  
16 cannot agree to the change to a manual, policy, or procedure  
17 document, the provider has the right to terminate the contract prior  
18 to the implementation of the change. In any event, the plan shall  
19 provide at least 45 business days' notice of its intent to change a  
20 material term, unless a change in state or federal law or regulations  
21 or any accreditation requirements of a private sector accreditation  
22 organization require a shorter timeframe for compliance.  
23 However, if the parties mutually agree, the 45 business day notice  
24 requirement may be waived. Nothing in this subparagraph limits  
25 the ability of the parties to mutually agree to the proposed change  
26 at any time after the provider has received notice of the proposed  
27 change.

28 (B) If a contract between a provider and a plan provides  
29 benefits to enrollees or subscribers through a preferred provider  
30 arrangement, the contract may contain provisions permitting a  
31 material change to the contract by the plan if the plan provides at  
32 least 45 business days' notice to the provider of the change and the  
33 provider has the right to terminate the contract prior to the  
34 implementation of the change.

35 (2) A provision that requires a health care provider to accept  
36 additional patients beyond the contracted number or in the absence  
37 of a number if, in the reasonable professional judgment of the  
38 provider, accepting additional patients would endanger patients'  
39 access to, or continuity of, care.

(3) A requirement to comply with quality improvement or utilization management programs or procedures of a plan, unless the requirement is fully disclosed to the health care provider at least 15 business days prior to the provider executing the contract. However, the plan may make a change to the quality improvement or utilization management programs or procedures at any time if the change is necessary to comply with state or federal law or regulations or any accreditation requirements of a private sector accreditation organization. A change to the quality improvement or utilization management programs or procedures shall be made pursuant to paragraph (1).

(4) A provision that waives or conflicts with any provision of this chapter. A provision in the contract that allows the plan to provide professional liability or other coverage or to assume the cost of defending the provider in an action relating to professional liability or other action is not in conflict with, or in violation of, this chapter.

(5) A requirement to permit access to patient information in violation of federal or state laws concerning the confidentiality of patient information.

~~(e) No contract issued, amended, or renewed on or after January 1, 2004, between a plan and a health care provider for the provision of health care services to a plan enrollee or subscriber shall require the contract to apply to patients other than those enrolled directly with the plan if the provisions of another contract would apply to the health care provider, unless the other contract terms do not vary from the underlying contract, or unless the other contract terms have otherwise been first negotiated and agreed to by the plan and the provider.~~

*(c) (1) In order to prevent the improper use of a health provider's contract when being sold, leased, or transferred, every arrangement that results in a payor paying a health care provider a reduced rate from billed charges for health care services based on the health care provider's participation in a network or panel shall be governed by the underlying contract between the health care provider and the contracting agent, regardless of the terms of the contract between the contracting agent and the payor.*

*(2) For purposes of this subdivision, the following terms shall have the following meanings:*

1 (A) “Contracting agent” has the meaning set forth in  
2 paragraph (2) of subdivision (d) of Section 1395.6.

3 (B) “Payor” has the meaning set forth in paragraph (3) of  
4 subdivision (d) of Section 1395.6.

5 (d) Any contract provision that violates subdivision (b) or (c)  
6 shall be void, unlawful, and unenforceable.

7 (e) The department shall compile the information submitted by  
8 plans pursuant to subdivision (h) of Section 1367 into a report and  
9 submit the report to the Governor and the Legislature by March 15  
10 of each calendar year.

11 (f) Nothing in this section shall be construed or applied as  
12 setting the rate of payment to be included in contracts between  
13 plans and health care providers.

14 (g) For purposes of this section the following definitions apply:

15 (1) “Health care provider” means any professional person,  
16 medical group, independent practice association, organization,  
17 health facility, or other person or institution licensed or authorized  
18 by the state to deliver or furnish health services.

19 (2) “Material” means a provision in a contract to which a  
20 reasonable person would attach importance in determining the  
21 action to be taken upon the provision.

22 ~~SEC. 2.~~

23 SEC. 3. Section 10178.4 is added to the Insurance Code, to  
24 read:

25 10178.4. (a) In order to prevent the improper use of a health  
26 provider’s contract when being sold, leased, or transferred, every  
27 arrangement that results in a payor paying a health care provider  
28 a reduced rate from billed charges for health care services based  
29 on the health care provider’s participation in a network or panel  
30 shall be governed by the underlying contract between the health  
31 care provider and the contracting agent, regardless of the terms of  
32 the contract between the contracting agent and the payor.

33 (b) For purposes of this section, the following terms shall have  
34 the following meanings:

35 (1) “Contracting agent” has the meaning set forth in  
36 paragraph (2) of subdivision (d) of Section 10178.3.

37 (2) “Payor” has the meaning set forth in paragraph (3) of  
38 subdivision (d) of Section 10178.3.

39 SEC. 4. Section 4610 is added to the Labor Code, to read:

1     4610. (a) *In order to prevent the improper use of a health*  
2 *provider's contract when being sold, leased, or transferred, every*  
3 *arrangement that results in a payor paying a health care provider*  
4 *a reduced rate from billed charges for health care services based*  
5 *on the health care provider's participation in a network or panel*  
6 *shall be governed by the underlying contract between the health*  
7 *care provider and the contracting agent, regardless of the terms of*  
8 *the contract between the contracting agent and the payor.*

9     (b) *For purposes of this section, the following terms shall have*  
10 *the following meanings:*

11     (1) *"Contracting agent" has the meaning set forth in*  
12 *paragraph (2) of subdivision (d) of Section 4609.*

13     (2) *"Payor" has the meaning set forth in paragraph (3) of*  
14 *subdivision (d) of Section 4609.*

15     SEC. 5. No reimbursement is required by this act pursuant to  
16 Section 6 of Article XIII B of the California Constitution because  
17 the only costs that may be incurred by a local agency or school  
18 district will be incurred because this act creates a new crime or  
19 infraction, eliminates a crime or infraction, or changes the penalty  
20 for a crime or infraction, within the meaning of Section 17556 of  
21 the Government Code, or changes the definition of a crime within  
22 the meaning of Section 6 of Article XIII B of the California  
23 Constitution.

